VIA ELECTRONIC DELIVERY

Marlene H. Dortch, Secretary
Federal Communications Commission
Office of the Secretary
445 12th Street, SW
Room TW-A325
Washington, DC 20554

Re: Colorado Telehealth Network – Request for Review of Decision of the Universal Service Administrator to deny eligibility of Longmont United Milestone Medical Group – Berthoud and Longmont United Milestone Medical Group – Niwot, WC Docket No. 02-60

Dear Secretary Dortch,

On behalf of the Colorado Telehealth Network ("CTN"), please find CTN's request for Review of Decision of the Universal Service Administrator.

CTN, pursuant to 47 C.F.R. §§ 601, 630(b), 719, respectfully requests that the following determination of ineligibility by USAC Rural Health Care Division be reviewed and decision reversed. Specifically, CTN respectfully requests that the Secretary rule that non-rural, non-profit clinics be deemed eligible if they are a part of a consortium application. In the alternative, CTN requests the Secretary rule that sites 17212-03-0006 and 17212-03-0005 ("Milestone Sites") are eligible as originally determined by USAC and per the standing FCC Healthcare Connect fund Rules and Order.

Should you have any questions, please do not hesitate to contact me.

Respectfully Submitted,

Robert Jenkins, MA
Program Manager
Colorado Telehealth Network

Colorado Telehealth Network: Appeal of USAC Eligibility Determination regarding HCP 17212 Milestone Medical Group Berthoud and Niwot Sites

Introduction and Summary

Pursuant to sections 54.719(c) and 54.720 of the Rules of the Federal Communication Commission ("FCC" or "Commission"), Colorado Telehealth Network ("CTN") (HCP # 17212, FCCRN 0017424656, SPIN 143001157) hereby respectfully requests review of the Denial of Eligibility issued by the Universal Service Administrative Company ("USAC") dated October 1, 2013. This denial was the result of a review conducted by USAC's Rural Health Care Division after notification to CTN and its member HCPs that all Health Care Providers ("HCPs") submitted by CTN in the FCC Form 465 Package were deemed eligible by USAC Rural Health Care Division staff and CTN notified of FCC Form 465 approval.

On 10/1/2013, Erin Crawford, USAC Rural Health Care Division Assistant Program Analyst, contacted Colorado Telehealth Network project coordinator Ed Bostick to inform the consortium that 2 sites, Milestone Medical Group – Niwot and Milestone Medical Group-Berthoud – sites that had previously been deemed eligible via USAC review as of mid-June 2013 – had been deemed ineligible upon additional review.

CTN therefore submits two reasons this determination be reversed. First, USAC's decision to rule "Non-rural Health Clinics" as ineligible even if they participate in an eligible consortium contracts the plain language of the HCF Order and its accompanying code sections. Second, USAC arbitrarily decided to re-review the eligibility of these sites contrary to the due process procedures prescribed by the Commission for such determinations. Further, since no reversal of current Rules and Order has been initiated by the Commission or USAC, CTN has been operating under the full understanding of said Rules and Order since December 2012.

For the reasons detailed below, CTN respectfully requests that the Secretary reverse the decision made by USAC on October 1, 2013 that "Non-rural Health Clinics" are ineligible for HCF

support even if they participate in an eligible consortium. In the alternative, CTN appeals the denial of eligibility for sites 17212-03-0006 and 17212-03-0005, Longmont United Milestone Medical Group – Berthoud and Longmont United Milestone Medical Group – Niwot.

Arguments:

Argument 1:

Argument Summary: USAC's determination that Non-rural Health Clinics are ineligible stands in direct contradiction of the HCF Order and accompanying FAQs, specifically paragraphs 59 through 61 of the HCF Order and paragraphs 9 through 12 of the HCF Order FAQs.

Argument: CTN respectfully requests that the Secretary reverse USAC's determination of eligibility for "Non-rural Health Clinic" sites because USAC's determination of eligibility contradicts the language of the Order and USAC's reasoning for criteria not explicitly stated in the HCF Order or HCF Order FAQs.

The Commission decided to "allow participation in the Healthcare Connect Fund consortia by both rural and non-rural eligible HCPs, [with limitations]." HCF Order para. 59. The Commission's reasons for allowing participation by non-rural eligible HCP's included: 1) primarily rural networks benefit from participation by larger non-rural HCP's; 2) many HCPs that are technically classified as non-rural within our rules in fact are located in relatively sparsely populated areas; and 3) even hospitals and clinics that are located in truly non-rural areas are able to provide significantly improved care by joining broadband networks. HCF Order para. 60. The Commission limited participation by non-rural eligible HCP's in three ways: 1) non-rural HCP's must participate in a consortium; 2) the consortium must consist of a majority of rural sites; and 3) the Commission established a cap on annual funding for hospitals licensed for more than 400 beds. Id. para 60. In defining Eligible Services, the Commission explicitly removed language referring to "rural" HCPs "because [the Commission allows] all HCPs to participate in consortia and receive support." HCF Order para. 111. The Commission justified its decision to decline to provide support

for administrative expenses in part because "[it] expand[ed] eligibility to include *all* HCPs [.]" HCF Order para. 174, (emphasis added). The plain language of the Commission in the HCF Order clearly communicates its intent to broadly apply subsidy to HCPs within a majority-rural consortium with only narrow regard to an individual HCP's rural/non-rural status.

In denying HCF eligibility for the Milestone Sites, USAC ruled that "Non-rural Health Clinics" are ineligible for subsidy citing 47 CFR § 54.600(a). HCP 17212 CHCC Cover Letter Denial of participating entity eligibility. No such code section presently exists. Presumably USAC intended to cite 47 CFR § 54.601(a), where the Code sets forth the HCF eligibility criteria for health care providers. It is true, as USAC notes in reference to Section 54.600(a), that Section 54.601(a) does list specifically "Non-rural Health Clinic" as an eligible site. However, the Code does list as eligible "[a c]onsortium of health care providers consisting of one or more entities [listed in this sub-section.]" 47 CFR § 54.601(a)(2)(vii). The Milestone Sites have applied for eligibility as part of the Colorado Telehealth Network, a previously approved consortium of health care providers consisting of 119 out of 195 (61%) rural entities explicitly listed in the Code as eligible. Therefore the Milestone Sites meet the eligibility requirements of the Code, and USAC must rule them as eligible for HCF subsidy.

While it is clear that USAC's intention in referencing Public Health Service Act Section 330 (42 USCS § 254b) is to provide clarification on the definition of a "community health center", in no place in either the HCF Order or the HCF Order FAQs, is section 330 referenced nor is the intention to reference section 330 articulated. Additionally, no such clarification is necessary in this case because the Milestone Sites meet the requirements of another eligible entity type.

Conclusion: The expectation that non-rural non-profit health care providers would be eligible for HCF funding support that is explicitly communicated in both the order and the order FAQs was a primary force behind CTN's decision to include both Milestone sites as eligible entities. This decision was reasonably justified both by the language of the HCF Order and by the language

contained in 47 CFR § 54.601(a). Further, the introduction of HRSA Section 330 criteria as a determinant of eligibility was neither justified in this case nor was it clearly communicated to CTN prior to CTN's submission of the 465 attachment in which both Milestone Medical Group sites were approved as eligible entity types. Based on the plain language of the HCF Order and its accompanying code sections, we ask you to rule that Non-rural Health Clinics participating in an eligible consortium are eligible for subsidy in the Healthcare Connect Fund.

Argument2:

Argument Summary: CTN determined eligibility for Milestone Medical Group sites based on erroneous instruction and guidance provided by USAC staff. USAC failed to meet timely notification expectations as outlined in paragraph 215 of the HCF Order. USAC arbitrarily and without notice decided to re-review site eligibility outside the time window prescribed by the HCF Order.

Argument: CTN respectfully requests the Secretary recognize that CTN acted in good faith upon USAC's recommendations for determining "eligible entity type" for both Milestones Sites – recommendations that proved to be ultimately erroneous – and reverse the determination of ineligibility and reinstate both Milestone sites as eligible for USAC subsidy. Further, USAC should reinstate Milestone sites because sites were planned for deployment based on eligibility confirmation provided by USAC on 6/17/13.

CTN submitted a completed Form 465 (instead of the prescribed 460 due to USAC's failure to timely complete processes for submission of the correct Form) on 6/12/13. USAC approved the submission on 6/17/13. As is clearly demonstrated in the attached timeline, the determination of eligibility for these sites was based on USAC staff member's explicit instructions on how to classify an non-rural non-profit clinic. USAC made its eligibility determinations based on these instructions. Paragraph 215 of the order provides USAC with 30 days to notify consortium applicants of its eligibility determination. It was not until 10/1/13, over three months after USAC's email on June

17, 2013 (attachment E) confirming the finalization of 465 attachment, that CTN was informed of site ineligibility.

CTN deployed Milestone Sites on 7/1/13 with the understanding that said sites were eligible based on the direct input of USAC staff. Had USAC staff correctly instructed CTN staff regarding the eligibility of these sites, both sites would have been informed of their ineligibility from the outset and never deployed. USAC declared the Milestone Sites ineligible nearly four months after sites were approved as eligible. In reliance on USAC's original eligibility determination, CTN's service provider deployed and the sites began operating under good faith assumptions about their eligibility and their receipt of USAC subsidy. To think that a small, not-for-profit clinic, regardless of location, would be able to withstand the financial impact of being required to pay for or forfeit services they had been informed they would be receiving at a subsidized rate is in direct contradiction to the opinion expressed in Paragraph 155 (specifically footnote 424) of the HCF Order.. An imposition of full "fair share" costs on a small non-profit HCP, regardless of location, could result in termination of service because the HCP is now responsible for an unanticipated and unplanned for expense.

USAC's reference to HRSA Section 330 and its intention to use this section to determine site eligibility was not communicated to CTN until 10/1/13, well after CTN had submitted sites for approval and had them approved by USAC staff (see argument 2). Had the intent to use HRSA Section 330 been articulated to consortium leaders as a critical key to determining eligible entity type prior to consortium leaders determining site eligibility, said criteria would have absolutely been taken into account. It's unreasonable to assume that participating consortia would have anticipated the inclusion of HRSA Section 330 criteria when that language does not appear anywhere in the HCF Order or FAQs. It is unreasonable to assume that sites deemed eligible based on the order's language below (see Exhibit B for full order text) and accompanying FAQs to forfeit

subsidy due to an omission of additional eligibility considerations in the original language of the HCF Order and FAQs.

USAC repeatedly instructed CTN regarding determining eligible entity type in the weeks leading up to CTN's Form 465 submission. USAC Manager of Consortia Applications, Camelia Rogers instructions to CTN staff on several occasions was the basis by which CTN determined that both Milestone sites were eligible (coupled with confirmation of non-rural non-profit eligibility in the HCF Order). These Sites are now contractually obligated to pay for 100% of the cost of services they were informed by USAC were eligible for HCF support. Had the information provided not indicated that both Milestone Sites were subsidy eligible by virtue of their "community health center" status, CTN would never have planned for and deployed the two Milestone locations.

Finally, CTN deployed these sites in good faith having not been notified by USAC of site ineligibility within the 21-day review window as outlined in Paragraph 300 of the HCF Order. While CTN understands that this 21-day period is not a guarantee of review and notification within 21 days, the order states that"[i]f USAC needs more than 21 calendar days to complete its initial review of the funding request, it should inform the applicant in writing that it needs additional time, and provide the applicant with a date on or before which it expects to provide [additional information.] USAC never notified CTN or the Milestone sites of any deficiency related to the eligibility of the Milestone Sites, nor did it notify CTN that USAC required additional time to review the eligibility of the Milestone Sites within the 21 day window. It is unreasonable to ask a consortium to anticipate an arbitrary eligibility review three months after USAC notifies the consortium that its sites are eligible. Had USAC notified CTN of its intention to re-review the approved 465 attachment, our consortium would have been prepared to respond within a reasonable timeframe to whatever decision USAC determined even if that determination fell somewhat outside of the 21 day window. USAC's failure to inform CTN in a reasonable timeframe around the 21 days after its 465 submission and approval and its demonstrated pattern of

providing contradictory eligible entity type coaching to CTN staff, is sufficient grounds to reverse USAC's determination of ineligibility. (PLEASE NOTE: a detailed accounting of the delivery of inaccurate eligibility determination instructions used to classify both Milestone locations to CTN by USAC staff and the less than timely release of eligibility judgments that brought about this dispute can be found in Attachments A through G).

Finally, it is critical that CTN address the negative impact the loss of sites previously deemed eligible presents in the context of network sustainability efforts. In an effort to become a self-sustaining network CTN, like many other consortiums nationally, rely on membership dues or service fees to support activities undertaken as consortium leaders. The loss of sites previously deemed eligible represents an unplanned and unforeseen negative financial impact to CTN as those lost fees have already been accounted for in revenue projections for CTN. As such, with no administrative support available in the Healthcare Connect Fun, the loss of sites previously deemed eligible places the consortium in a position of having to augment current activities to recoup the revenue of lost sites.

Conclusion: USAC acted arbitrarily and unreasonably in instructing CTN as to the proper classification of the Milestone Sites, determining the Sites eligible, then re-reviewing eligibility and reversing itself. At no point did USAC make an attempt to convey its intention to employ HRSA Section 330 characteristics to eligible entity type determinations. The fact that USAC did not inform consortium leaders of the inclusion of HRSA Section 330 criteria to the eligible entity types listed in the Form 465 anywhere within 21-days of its 465 submission coupled with its failure to communicate that information until October 1, 2013, after CTN's form 465 was approved, provides sufficient basis for reversal of USAC's non-eligibility determination of 10/1/13. Further, contrary to the intent of the HCF order which states, "…Pilot Program provides support for a limited number of years for up to 85 percent of the eligible costs of broadband HCP networks, with the requirement that such networks be self- sustainable thereafter.[233]" HCF Order para. 81. This determination

negatively impacts CTN's efforts to become a self-sustaining organization by effectively reducing the expected and planned for revenue CTN would obtain from the Milestone sites.

Because USAC acted arbitrarily and failed to follow due process prescribed by the Commission, we respectfully request that the Secretary reverse the ineligibility determination of Colorado's Milestone sites as received by USAC on 10/1/13 and reinstate them as subsidy eligible.

Exhibit A: Notice of Denial of Eligibly for Longmont United Milestone Medical Group's Berthoud and Niwot Clinics

Rural Health Care Division

USAC
Universal Service Administrative Company

Via Electronic Mail

10/01/2013

Ed Bostick
7335 East Orchard Road
Greenwood Village, CO 80111

RE: HCP 17212 Denial of Eligibility for 2 HCP's Longmont United Hospital District- Milestone Medical Group-Berthoud and Longmont United Hospital District- Milestone Medical Group-Niwot

Dear Ed Bostick:

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) received and initially reviewed the FCC Form 465 Package[1] submitted by HCP 17212, Colorado Health Care Connections on June 12, 2013. [2] USAC finalized processing the FCC Form 465 Package on July 29, 2013 with the posting of the competitive bidding package to the USAC search posted services website. [3] However, upon further review, several of the entities listed on the FCC Form 465 Attachment are not eligible to participate in the Healthcare Connect Fund.

In the Rural Health Care Pilot Program (RHCPP), entities that are "Urban Health Clinics" were eligible to participate and receive funding. The Pilot Program FCC Form 465 Attachment in Column 27(b) contained a dropdown menu with "Urban Health Clinic" as one of the Eligible Entity Types. Please note however that "Non-rural Health Clinic" is not an eligible entity type for purposes of the Healthcare Connect Fund. [4]

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[1] The FCC Form 465 Package includes the FCC Form 465 and all supporting documentation; including but not limited to, the Form, 465 Attachment, Network Plan, Scoping Document, Letters of Agency and Declaration of Assistance.

[2] As an existing Rural Health Care Pilot Program Pilot Project, Bacon County Health Services is allowed by the Healthcare Connect Fund Order to use existing Pilot Program forms to initiate competitive bidding for purposes of requesting funding through the Healthcare Connect Fund. *In the Matter of Rural Health Care Support Mechanism*, WC Docket 02-60, Report and Order, FCC

12-150, 22 FCC Rcd 16678 (2012) (*Healthcare Connect Fund Order*). "Existing Pilot Projects" refers to active Pilot Projects selected in the *2007 Pilot Program Selection Order,* including projects that have subsequently merged or otherwise restructured. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360 (2007) (*2007 Pilot Program Selection Order*).

Entities that participated in the RHCPP as an "Urban Health Clinic" and received funding via the issuance of a Funding Commitment Letter as of the adoption date of the Healthcare Connect Fund Order[5] are eligible for funding as a "grandfathered entity" in the Healthcare Connect Fund. Alternatively, an "Urban Health Clinic" that meets the requirements of Section 330 of the Public Health Service Act[6] may be classified as a "Community Health Center" for purposes of participation in the Healthcare Connect Fund.

Upon further review of the "Urban Health Clinics" and the services they provide (as listed on the FCC Form 465 Attachment submitted by CHCC), USAC finds that they do not meet the definition of a "Community Health Center" as defined by the Public Health Services Act, Section 330. USAC also determined that those entities did not previously receive a funding commitment through the RHCPP as of December 12, 2012 and are therefore not eligible for "grandfathered entity" status under the Healthcare Connect Fund.

Although the above mentioned entities are not eligible to receive funding, they may register as an "Ineligible entity" if they plan to participate as part of a consortium, thus receiving the benefits of membership of a consortium.
If you wish to appeal this decision, you may file an appeal with USAC, or directly to the FCC. The appeal **must be filed within 60 days of the date of this letter.** Detailed instructions for filing appeals are available at:
http://www.usac.org/rhc/about/program- integrity/appeals.aspx?pgm=telecom

If you have questions or need assistance, or if you believe you have received this email in error, contact Rural Health Care at 1-800-453-1546, between 8:00 a.m. and 4:30 p.m. Eastern Time Monday through Friday, or by email at rhc-assist@usac.org.

Sincerely,

/s/ Rural Health Care Division

[3] http://www.usac.org/rhc/healthcare-connect/tools/search-posted-services.aspx, last visited September 6, 2013.

[4] 47 C.F.R. § 54.600(a)
[5] *Healthcare Connect Fund Order* was adopted by the FCC on December 12, 2012.
[6] http://bphc.hrsa.gov/policiesregulations/legislation/authorizing330.pdf, last visited August 6, 2013.

2000 L Street, N.W. Suite 200 Washington, DC 20036 Voice 202.776.0200 Fax 202.776.0080 www.usac.org

Rural Health Care Division

Via Electronic Mail

10/01/2013

Ed Bostick
7335 East Orchard Road
Greenwood Village, CO 80111

RE: Rural Health Care FCC Form 465 – Denial
HCP Number: 17212
HCP Name: Longmont United Hospital District – Milestone Medical Group-Niwot

Dear Ed Bostick:

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) received and reviewed the FCC Form 465 submitted by HCP 17212, Colorado Health Care Connections (CHCC). CHCC submitted the FCC Form 465 listing the above named entity as a participating entity for which USAC reviewed the HCP's eligibility to participate in the Healthcare Connect Fund. An HCP must meet two criteria in order to be eligible to participate:

1. The HCP must be a public or non-profit health care provider (see 47 C.F.R. § 54.601(a)).
2. The HCP must qualify as one of the following (see 47 C.F.R. § 54.600(a)):
   - Post-secondary educational institution offering health care instruction, teaching hospital, or medical school
   - Community health center or health center providing health care to migrants
   - Local health department or agency
   - Community mental health center
   - Not-for-profit hospital

- Rural health clinic including mobile clinic
- Dedicated emergency room of a for-profit hospital
- Part-time eligible entity located in otherwise ineligible facility

An HCP that does not meet these two criteria is not eligible to participate in the RHC Healthcare Connect Fund program. Based on the information provided on the submitted FCC Form 465, RHC has determined that the HCP referenced above is not eligible to participate because the HCP has been identified as:

A for-profit HCP ☐ An ineligible HCP type ■

The above named HCP was listed on the FCC Form as a "Community Health Center". USAC reviewed the services provided by HCP 17212, Longmont United Hospital District – Milestone Medical Group-Niwot, and finds that it does not meet the definition of a "Community Health Center" as defined by the Public Health Services Act, Section 330.

If you wish to appeal this decision, you may file an appeal with USAC, or directly to the FCC.

The appeal **must be filed within 60 days of the date of this letter.** Detailed instructions for filing appeals are available at: http://www.usac.org/rhc/about/program- integrity/appeals.aspx?pgm=telecom

If you have questions or need assistance, or if you believe you have received this email in error, contact Rural Health Care at 1-800-453-1546, between 8:00 a.m. and 4:30 p.m. Eastern Time Monday through Friday, or by email at rhc-assist@usac.org.

Sincerely,

/s/ Rural Health Care Division

Cc: HCP 17212, Colorado Health Care Connections Consortium

Rural Health Care Division

USAC
Universal Service Administrative Company

Via Electronic Mail

10/01/2013

Ed Bostick
7335 East Orchard Road
Greenwood Village, CO 80111

RE: Rural Health Care FCC Form 465 – Denial
HCP Number: 17212
HCP Name: Longmont United Hospital District – Milestone Medical Group- Berthoud

Dear Ed Bostick:

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) received and reviewed the FCC Form 465 submitted by HCP 17212, Colorado Health Care Connections (CHCC). CHCC submitted the FCC Form 465 listing the above named entity as a participating entity for which USAC reviewed the HCP's eligibility to participate in the Healthcare Connect Fund. An HCP must meet two criteria in order to be eligible to participate:

1. The HCP must be a public or non-profit health care provider (see 47 C.F.R. § 54.6 1(a)).

2. The HCP must qualify as one of the following (see 47 C.F.R. § 54.600(a)):
   - Post-secondary educational institution offering health care instruction, teaching hospital, or medical school
   - Community health center or health center providing health care to migrants
   - Local health department or agency
   - Community mental health center
   - Not-for-profit hospital
   - Rural health clinic including mobile clinic
   - Dedicated emergency room of a for-profit hospital
   - Part-time eligible entity located in otherwise ineligible facility

An HCP that does not meet these two criteria is not eligible to participate in the RHC Healthcare Connect Fund program. Based on the information provided on the submitted FCC Form 465, RHC has determined that the HCP referenced above is not eligible to participate because the HCP has been identified as:

A for-profit HCP ☐ An ineligible HCP type ■

The above named HCP was listed on the FCC Form as a "Community Health Center". USAC reviewed the services provided by HCP 17212, Longmont United Hospital District – Milestone Medical Group-Berthoud, and finds that it does not meet the definition of a "Community Health Center" as defined by the Public Health Services Act, Section 330.

If you wish to appeal this decision, you may file an appeal with USAC, or directly to the FCC.

The appeal **must be filed within 60 days of the date of this letter.** Detailed instructions for filing appeals are available at: http://www.usac.org/rhc/about/program- integrity/appeals.aspx?pgm=telecom

If you have questions or need assistance, or if you believe you have received this email in error, contact Rural Health Care at 1-800-453-1546, between 8:00 a.m. and 4:30 p.m. Eastern Time Monday through Friday, or by email at rhc-assist@usac.org.

Sincerely,

/s/ Rural Health Care Division

Cc: HCP 17212, Colorado Health Care Connections Consortium

Exhibit B: Paragraphs 56 through 61 of the order and paragraphs 9 through 12 of the order FAQs.

Order ¶ 56 through 61 Rural Health Care Support Mechanism WC Docket No 02-60:

56. In light of these benefits, we adopt a number of rules adopted today to encourage HCPs to work together in consortia to meet their broadband connectivity needs. Immediately below, we conclude that non-rural HCPs may participate and receive support as part of consortia, with some limitations. We also adopt a "hybrid" approach that allows consortia to receive support through a single program for services and, where necessary, self-construction of infrastructure.[140] We adopt a uniform HCP contribution percentage applicable to all HCPs and to all funded costs to simplify administration.[141] In sections V and VI below, we adopt additional measures. We make support for certain costs available only to consortia – *e.g.,* upfront payments for build-out costs and IRUs, equipment necessary for the formation of networks, and self-construction charges.[142] We also allow consortia to submit a single application covering all members, and we provide additional guidance based on Pilot Program experience for consortium applications.[143] Finally, we facilitate group buying arrangements by providing for multi- year commitments and allowing HCPs to "opt into" competitively bid master service agreements previously approved by USAC or other federal, state, Tribal, or local government agencies, without undergoing additional competitive bidding solely for the purposes of receiving Healthcare Connect Fund support.[144]

(Continued from previous page)

connections within the network terminate at an eligible rural entity. USAC Observations Letter at 5. As a technical and financial matter, this can lead to less efficient network design. For example, it may be more efficient to design the middle-mile component of a regional or statewide network by using connections between non-rural sites, rather than routing traffic through a rural site. *Id*.

[138] *See Pilot Evaluation,* 27 FCC Rcd at 9436-37, paras. 81-83; *see also* USAC Observations Letter at 1-2 (use of centralized contracting and invoicing; use of Master Services Agreements). The Commission's experience with the Pilot Program shows that consortium applications drive down costs and make it possible for HCPs to purchase higher capacity services. Service providers bidding on consortium RFPs are more willing to offer larger discounts because the consortium has multiple sites and presents a more appealing commercial proposition to the service providers. Consortium applications also encourage vendors to bid on providing broadband to sites where broadband might not already be available, because a single RFP includes all consortium HCP sites (both those that have broadband available to them and those that do not). *See Pilot Evaluation*, 27 FCC Rcd at 9437, para. 82.

[139] *See, e.g.,* Broadband Principals Comments at 10 (the reality is that many small HCPs may prefer to run their telecommunications through a group which can provide expertise and help them realize economies of scale); Internet2 Comments at 17; ACS PN Comments at 3; Geisinger PN Comments at 2; NCTN PN Comments at 2; UTN PN Comments at 1.

[140] *See infra* section IV.C.

[141] *See infra* section IV.D.

[142] *See infra* sections V.A.6, V.B, IV.C.

[143] *See generally infra* section VI.

[144] *See infra* sections VI.C.4, VI.B.6.

2. Eligibility to Participate in Consortia

57. *Background*. As noted above, the existing RHC programs (both Telecommunications and Internet Access) provide support only to HCPs located in "rural" areas. "Rural area" is defined based on the location of a HCP site relative to a Core Based Statistical Area (CBSA), a geographic area based around an non-rural center of at least 10,000 people.[145] In contrast, the Pilot Program allowed participation by both rural and non-rural eligible HCPs, as long as a project had more than a *de minimis* representation of rural HCPs.[146] As of November 15, 2012, all but one of the 50 active Pilot projects included at least one participant that was not a rural HCP.[147] The non-rural sites represented approximately 34 percent of the 3,822 Pilot project sites and approximately 39 percent of the funding commitments for all projects as of November 15, 2012.[148]

58. In the *NPRM*, the Commission proposed to allow non-rural participation in the Health Infrastructure Program, but not in the Broadband Services Program.[149] The Bureau sought additional comment on including non-rural sites for broadband services funding in the *July 19 Public Notice*.[150] A diverse group of commenters – including state offices of rural health, Pilot projects, the American Hospital Association, service providers, and United Way – have urged the Commission to support both non-rural and rural HCPs, citing the many benefits of non-rural participation in broadband health care

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[145] *See* 47 C.F.R. § 54.5. Specifically, "rural area" is defined as an "area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Non-rural Area with a population of
25,000 or greater; or is in a Core Based Statistical Area that contains an Non-rural Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Non-rural Area with a population of greater than 25,000." CBSAs are defined by the Office of Management and Budget (OMB) and "Non-rural Areas" and "Places" are identified by the Census Bureau. *See Rural Health Care Second Report and Order and Further Notice*, 19 FCC Rcd at 24619-20, para. 12 & nn.44-47 (explaining the basis for the current definition of "rural area"). USAC maintains a "lookup table" on its website to enable applicants quickly to determine if their location is "rural" under this definition. *See* USAC web site, "List of Eligible Rural Areas," *available at* http://www.universalservice.org/rhc/tools/Rural/2005/search.asp (last visited Nov. 7, 2012).

[146] *2006 Pilot Program Order,* 21 FCC Rcd at 11111, 11114, paras. 3, 10.

[147] USAC Nov. 16 Data Letter at 4.

[148] *Id.* at 1-2. As noted in the *Pilot Evaluation*, the funding attributed to non-rural locations likely is overstated because shared equipment and services often are attributed to non-rural locations even though they are used by all the network sites. *See also Pilot Evaluation*, 27 FCC Rcd at 9408, para. 37; Letter from Craig Davis, Vice President, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 (filed May 30, 2012) at 2 (USAC May 30 Data Letter). In addition to network design studies, "shared" equipment and services (*i.e.*, equipment and services that
benefit the entire network and not just one site) would include switches, routers, and firewalls that are located at data centers or other facilities of lead entities that often are located in non-rural areas. *Id* at 2-3.

[149] *See NPRM*, 25 FCC Rcd at 9739, 9408, paras. 13, 93.

[150] *See July 19 Public Notice* at paras. 7-8.

networks.[151] A few commenters, however, have raised concerns that program funds could be exhausted if non-rural HCPs are made eligible for support without any limitations.[152]

59. *Discussion*. We will allow participation in the Healthcare Connect Fund consortia by both rural and non-rural eligible HCPs, but with limitations to ensure that the health care support mechanism continues to serve rural as well as non-rural needs in the future. The Pilot Program provided support to both rural and non-rural HCPs under section 254(h)(2)(A), which directs the Commission to "enhance… access to advanced telecommunications and information services for *all* public and non-profit . . . health care providers."[153] As the Fifth Circuit has found, "the language in section 254(h)(2)(A) demonstrates Congress's intent to authorize expanding support of 'advanced services,' when possible, for non-rural health providers."[154]

60. We expect that including non-rural HCPs in consortia will provide significant health care benefits to both rural and non-rural patients, for at least three reasons.

- First, even primarily rural networks benefit from the inclusion of larger, non-rural HCPs.[155] Pilot projects state that rural HCPs value their connections to non-rural HCPs for a number of reasons, including access to medical specialists; help in instituting telemedicine programs; leadership; administrative resources; and technical expertise.[156] Many non-rural HCPs in the Pilot Program devoted resources to organizing consortia, preparing applications, designing networks, and preparing RFPs.[157] Had these non-rural HCPs not been eligible for support, they might not have been willing to take on a leadership role, which in turn directly enabled

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[151] *See, e.g.*, NOSORH Comments at 4 (inclusion of non-rural HCPs in a dedicated health care network is "essential for access to services otherwise unavailable"); CTN PN Comments at 5-6; IRHN PN Comments at 7-8; UTN PN Comments at 3; CTCC/RMHN PN Comments at 2; OHN PN Comments at 5; AHA PN Comments at 2; GCI PN Comments at 6; Charter PN Reply Comments at 4; United Way PN Comments at 2. The benefits cited by these commenters are similar to those discussed in the *Pilot Evaluation. See Pilot Evaluation,* 27 FCC Rcd at 9439-9442, paras. 88-90.

[152] *See, e.g.,* AHA PN Comments at 3 (Commission should allow non-rural participation in consortia, but ensure that the program's limited funding be used for the benefit of rural HCPs); RWHC PN Comments at 2 (agreeing with the importance of including non-rural referral centers in rural broadband networks, and supporting funding for non-rural HCPs in rural broadband networks to the extent that the funding for non-rural HCPs is not at the expense of rural HCPs); ACS PN Comments at 5; CHCC/RMHN Comments at 3.

[153] 47 U.S.C. § 254(h)(2(A) (emphasis added).

[154] *Texas Office of Public Utility Counsel v. FCC*, 183 F.3d at 446 (subsequent history omitted). The only statutory limitation is that HCPs must be public or non-profit entities and must be within one of the eligible statutory HCP categories. *See* 47 U.S.C. §§ 254(h)(2)(A), 254(h)(7)(B) (listing categories of eligible HCPs). In contrast, the Telecommunications Program, which limits support to rural HCPs, was implemented pursuant to a different provision of the 1996 Act, section 254(h)(1)(A), which requires telecommunications carriers to provide telecommunications services to "any public or nonprofit HCP that serves persons who reside in *rural* areas in the State at rates that are reasonably comparable to rate charged for similar services in non-rural areas in that State." 47
U.S.C. § 254(h)(1)(A) (emphasis added). The Telecommunications Program therefore is only available to rural HCPs.

[155] *Pilot Evaluation*, 27 FCC Rcd at 9439-42, paras. 88-89; *see supra* section IV.B.1, para. 54.

[156] *Pilot Evaluation*, 27 FCC Rcd at 9439-42, para. 89 (many Pilot projects state that participation by non-rural sites has been instrumental to their individual success).

[157] *See, e.g.*, UTN PN Comments at 3; IRHN PN Comments at 7; MiCTA PN Comments at 3; SWTAG PN Comments at 6; HSHS PN Comments at 4; VAST PN Reply Comments a 1; OHN PN Comments at 6.

smaller and more rural HCPs to participate in Pilot networks.[158] The participation of non- rural sites has also led to better prices and more broadband for participating rural HCPs, due to the greater bargaining power of consortia that include larger, non-rural sites.[159]

- Second, the Commission's longstanding definition of "non-rural" HCPs encompasses a wide range of locales, ranging from large cities to small towns surrounded by rural countryside.[160]
  Even within areas that are primarily rural, HCPs are likely to be located in the most populated areas. Many HCPs that are technically classified as non-rural within our rules in fact are
  located in relatively sparsely populated areas. For example, Orangeburg County Clinic in Holly Hill, South Carolina (population 1,277), a HCP participating in Palmetto State Providers Network's Pilot project, is characterized as non-rural. The largest cities closest to
  Holly Hill are Charleston, SC, and Columbia, SC, which are respectively 50 and 69 miles away from Holly Hill.[161] Moreover, even those hospitals and clinics that are located in more densely populated towns directly serve rural populations because they are the closest HCP for many patients who do live in the surrounding rural areas.[162] For example, the University of Virginia Medical Center is a major referral center for many counties in rural Appalachia.[163]
- Third, even hospitals and clinics that are located in truly non-rural areas are able to provide significantly improved care by joining broadband networks. The California Telehealth Network, for example, states that it "frequently encounters non-rural health care providers with patient populations that are as isolated from clinical specialty care as [the] most rural health care providers," including non-rural Indian HCPs who could better serve Native populations through broadband-centered technologies such as EHRs and telemedicine.[164] In some areas of the country, even "non-rural" communities may be hundreds of miles away from critical health care services such as Level 1 Trauma Centers, academic health centers, and children's hospitals.[165] Like HCPs in rural areas, these "non-rural" community hospitals may serve as "spoke" health care facilities that access services that are available at larger hospital "hubs." Eligible public and not-for-profit HCPs located in communities that are not classified as

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[158] *See supra* para. 54. *See also Pilot Evaluation*, 27 FCC Rcd at 9439-42, para. 89.

[159] *Pilot Evaluation*, 27 FCC Rcd at 9437, para. 82; *see also*, *e.g.*, UTN PN Comments at 2; CRIHB PN Reply Comments at 1; NETC PN Reply Comments at 3-5; VAST PN Reply Comments at 1.

[160] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20421, para. 120; 47 C.F.R. § 54.5. OMB has cautioned that "[t]he CBSA classification is not an non-rural-rural classification" and that CBSAs and many counties outside CBSAs "contain both non-rural and rural populations." Office of Management and Budget, 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas, 75 Fed. Reg. 37245, 37249 (June 28, 2010), *available at*
http://www.whitehouse.gov/sites/default/files/omb/assets/fedreg_2010/06282010_metro_standards-Complete.pdf (last visited Nov. 7. 2012).

[161] For an interactive map that shows the rural/ non-rural categorization of the Pilot Program HCP sites, *see Pilot Evaluation*, 27 FCC Rcd at 9406, para. 34 (citing map at http://www.fcc.gov/maps/rural-health-care-pilot-program). An examination of the sites on the map shows that many of the non-rural HCP sites in the Pilot Program are located in or near areas with relatively low density populations.

[162] *See*, *e.g.*, NCTN Comments at 9; CTN PN Comments at 6.

[163] UVA June 8 *Ex Parte* Letter at 1 (UVA provides tele-psychiatry that is vital for patients in rural areas of

Virginia, given that only one or two psychiatrists serve all of southwestern Virginia; the tele-psychiatry program has transformed a 50 percent patient "no-show" rate to an 85 percent "show" rate).

[164] CTN PN Comments at 6; CRIHB PN Reply at 1.

[165] UTN PN Comments at 2 (noting this is true in Utah and other areas of the intermountain west).

"rural" thus have a need for access to broadband to be able to effectively deliver health care, just as their "rural" counterparts do.

61. Some commenters express concern that unlimited non-rural HCP participation might jeopardize funding for rural HCPs if the $400 million annual program cap is reached.[166] We therefore adopt three simple limitations that should help ensure a fiscally responsible reformed health care program without unduly restricting non-rural participation, consistent with our statutory mandate to enhance access to advanced services in an "economically reasonable" manner.[167] First, non-rural HCPs may only apply for support as part of consortia that include rural HCPs; that is, they may not submit individual applications.[168] Second, non-rural HCPs may receive support only if they participate in consortia that include a majority (more than 50 percent) of sites that are rural HCPs. The majority rural requirement must be reached by a consortium within three years of the filing date of its first request for funding (Form 462) in the Healthcare Connect Fund. Third, we establish a cap on the annual funding available to each of the largest hospitals participating in the program (those with 400 or more beds). These requirements will encourage the formation of health care *networks* that include rural HCPs, while generating administrative and pricing efficiencies as well as significant telemedicine and other telehealth benefits.[169]

Frequently Asked Questions ¶ 9 through 11 Rural Health Care Support Mechanism WC Docket No 02-60:

9. What HCPs are eligible to receive support under the Healthcare Connect Fund?

Public and not-for-profit health care providers are eligible to receive support under the Healthcare Connect Fund. "Health care provider" is defined by statute as hospitals, rural health clinics, local health departments, community health centers or health centers providing health care to migrant workers and post-secondary educational institutions offering heath care instruction, teaching hospitals, and medical schools. *See* 47 USC § 254(h)(7). As discussed below in Question 11, non-rural HCPs may participate and receive support as part of consortia that include a majority rural HCP sites. *See* *HCF Order** at paras. 44-67 for additional details on HCP eligibility. Ineligible HCP sites also may participate in a consortium, but they will not receive support (they must pay "fair share"). *See* *HCF Order** at paras. 178-184 for additional details on cost allocation for ineligible entities.

10. How can an HCP find out if it is an eligible entity?

USAC will use the FCC Form 460 to determine whether a site is eligible to receive support through the Healthcare Connect Fund. All sites, whether considered eligible or ineligible HCPs, must file a Form 460, even if they were previously determined to be eligible under the Telecommunications, Internet Access, or Pilot programs. *See* Question 8 (above) and *HCF Order** at paras. 213-215 for additional information.

11. Can non-rural HCPs receive Healthcare Connect Fund support?

Yes. Non-rural HCPs can receive support from the program, as long as they apply as part of a consortium that has a majority rural HCP sites and are otherwise considered eligible. However, non-rural hospital sites with 400 or more licensed beds may receive no more than $30,000 per year in support for recurring charges and no more than $70,000 in support for non-recurring charges every five years, exclusive of any costs shared by the network. *See* *HCF Order** at paras. 57-67 for additional details.

12. What does it mean for a consortium to be considered "majority rural"?

A consortium is considered to be "majority rural" if more than 50 percent of the eligible HCP sites participating in the consortium are rural within the Commission's rural health care definition of rural. A consortium applicant must be majority rural within three years of obtaining its first funding commitment. *See* *HCF Order** at para. 61 for additional details.

Attachments A through G:
Accounting of guidance communicated to Debby Farreau, Assistant Project Coordinator, Colorado Telehealth Network Program Director, from Camelia Rogers, USAC Manager of Consortia Applications.

- The timeline below illustrates a consistent pattern of guidance provided by USAC to CTN staff that resulted in the Milestone Medical Group's Berthoud and Niwot clinics being deployed on 7/1/13 as subsidy eligible sites. This pattern also makes clear that erroneous eligibility determination instructions were repeatedly provided to CTN staff by title and confirmed by title. This pattern of consistent guidance clearly places the onus of responsibility on USAC for failing to correctly instruct CTN staff on determining the eligibility of non-rural, not-for-profit healthcare providers. As such, we ask that the Secretary recognize USAC's responsibility to provide Colorado Telehealth Network timely and accurate information and guidance and (1) reverse the decision to revoke eligibility and (2) restore subsidy for the Milestone connections. Camelia Rogers, Manager of Consortia Applications instructs Debby Farreau, Assistant Project Coordinator on 5/31/13: "Non-rural non-profit clinics should be identified as community health clinics. Rural non-profit community health centers should be listed as community health centers. Rural non-profit health clinics should be listed as a rural health clinic." – **Attachment B**
- Ms. Ferreau contacts Ms. Rogers and Ms. Crawford for confirmation that the "community health clinic" is the correct designation for non-rural non-profit clinics. Camelia replies on 6/3/13: "A non-profit clinic that provides healthcare services and is located in an non-rural area should be listed as a Community Health Center for purposes of obtaining funding from the Rural Healthcare Support Mechanism. The FCC has not defined what a "community health center" means, so any non-profit health care provider that provides healthcare services to the community is eligible for funding" – **Attachment**
- Ms. Farreau modifies 465 attachment and classifies sites in column 27b (eligibility entity type) dropdown using Ms. Roger's explicit criteria above to inform the designation of "Community Health Center" for Longmont Milestone Medical Group Locations. – **Attachment D**
- Ms. Crawford contacts Ms. Ferreau on 6/12/13 to indicate that, after review, CTN has only four (4) ineligible sites. The ineligible sites are Jefferson Center for Mental Health in Aurora, Colorado West Regional Mental Health, Inc. – Women's Recovery Center and the Jefferson Center for Mental Health in Lakewood. – **Attachment E**
- Ms. Crawford contacts Ms. Farreau on 6/17/13 to indicate, "I have uploaded your 465-Attachment including the newly eligible sites to Sharepoint. You should be good to go as all of the new sites were reviewed and their eligibility status should be reflected in the 465-Attachment that is now uploaded to the Sharepoint site. Please do not hesitate to contact us with any further questions or comments regarding your project. A copy of the newly uploaded 465 Attachment is copied with this email." Please note that in the approved 465 Erin forwards to Debby on 6/17/13 indicates that both Milestone-Niwot and Milestone-Berthoud are eligible for funding as "2: Community health center or health center providing health to migrants." - **Attachment F**
- USAC determines that these sites are not eligible on 7/29/13 and informs CTN on 10/1/13, three months after sites have been deployed based on approved eligibility designations obtained and confirmed by USAC. – **Attachment G**

Attachment A:
Communication between Debby Farreau, Assistant Project Coordinator, and Camelia Rogers, USAC Manager of Consortia Applications. 5/31/13

From: Camelia Rogers [mailto:crogers@usac.org]
Sent: Friday, May 31, 2013 4:49 AM
To: Debby Farreau
Cc: Ed Bostick; Erin Crawford
Subject: RE: Eligibility Review

Debby

That's fine, we will review all of the HCPs for eligibility. Non-rural non-profit health clinics should be identified as community health clinics. Rural non-profit community health centers should be listed as community health centers. Rural non-profit health clinics should be listed as a rural health clinic.

Thanks,
Camelia

Please take note, my office number has changed to 202-772-6289

Camelia L. Rogers, MPP
Manager of Consortia Applications
Rural Health Care Division
202-772-6289 (office)
202-341-7439 (blackberry)
crogers@usac.org

From: Debby Farreau [mailto:Debby.Farreau@cha.com]
Sent: Thursday, May 30, 2013 4:55 PM
To: Camelia Rogers
Cc: Ed Bostick
Subject: RE: Eligibility Review

Camelia,
Thanks for the preliminary review. I have a few questions/comments (please see below in red))
Thanks,
Debby

From: Camelia Rogers [mailto:crogers@usac.org]
Sent: Thursday, May 30, 2013 12:29 PM
To: Debby Farreau; Ed Bostick
Cc: Donald Lewis; Erin Crawford
Subject: Eligibility Review

Debby

A preliminary review of the documentation provided has been done and there are several issues that we will work with you to resolve. The action that we have taken thus far:

- Deleted FCC Form 465 from SharePoint: Since CTN is not initiating a competitive bid, a Form 465 is not necessary.
- Modified RFP number to 03 on the 465 Attachment in order to allow for a new set of 465 app numbers to be created for the new locations
- Modified names of documents on SharePoint: titles of all of the documents uploaded have been modified to remove (posted) from the names of the documents.
- Cursory review of the CMHC checklists. It appears that some of the locations are eligible and some are not eligible. We will send you a complete listing of the issues that we have identified I thought a few of the Mental Health Center locations were ineligible but those sites insisted I submit them to you to make the final eligibility determination.
- Cursory review of the 465 attachment --- numerous HCP's are listed with incorrect Eligible Entity types. We would ask that Colorado Telehealth Network review the 465 Attachment and modify the eligible entity types to reflect the actual services provided at the physical locations. For example, there are multiple locations with "Not for profit Hospital" listed as the eligible entity type, but the description of services indicate that this is a Clinic. A clinic is not a hospital (even if owned by a hospital) and the eligible entity type needs to be modified to reflect the services provided at that physical location. If the hospital owned clinic is in a rural location is the correct selection "Rural Health Clinic" and for those in non-rural locations "Community Health Center"?

Please let me know once you have modified the 465 attachment. In the meantime, we are working on sending you a listing of the issues that we have found.

Thanks,
Camelia

Please take note, my office number has changed to 202-772-6289

Camelia L. Rogers, MPP
Manager of Consortia Applications
Rural Health Care Division
Universal Service Administrative Company
202-772-6289 (office)
202-341-7439 (blackberry)
crogers@usac.org

Attachment B:
Communication between Debby Farreau, Assistant Project Coordinator, and Camelia Rogers, USAC Manager of Consortia Applications confirming instruction provided on 5/31/13 on 6/3/13.

From: Camelia Rogers [mailto:crogers@usac.org]
Sent: Monday, June 03, 2013 2:08 PM
To: Debby Farreau
Cc: Erin Crawford
Subject: Community Health Center

Debby,

A non-profit clinic that provides healthcare services and is located in an non-rural area should be listed as a Community Health Center for purposes of obtaining funding from the Rural Healthcare Support Mechanism. The FCC has not defined what a "community health center" means, so any non-profit health care provider that provides healthcare services to the community is eligible for funding.

Thanks,
Camelia

Camelia L. Rogers, MPP
Manager of Consortia Applications
Rural Health Care Division
Universal Service Administrative Company
202-772-6289 (office)
202-341-7439 (blackberry)
crogers@usac.org

Attachment C:
Communication between Debby Farreau, Assistant Project Coordinator, and Camelia Rogers, USACManager of Consortia Applications confirming changes to 465 attachment based on Camelia's instructions on 6/3/13 on 6/4/13.

From: Camelia Rogers [mailto:crogers@usac.org]
Sent: Tuesday, June 04, 2013 2:12 PM
To: Debby Farreau; Ed Bostick
Cc: Donald Lewis; Erin Crawford; Ed Bostick
Subject: RE: Eligibility Review

Okay, great!!!

Thanks,
Camelia

From: Debby Farreau [mailto:Debby.Farreau@cha.com]
Sent: Tuesday, June 04, 2013 4:11 PM
To: Camelia Rogers; Ed Bostick
Cc: Donald Lewis; Erin Crawford; Ed Bostick
Subject: RE: Eligibility Review

I only changed the eligibility type in column 27b. I did not change the descriptions in column 27c.

From: Camelia Rogers [mailto:crogers@usac.org]
Sent: Tuesday, June 04, 2013 1:47 PM
To: Debby Farreau; Ed Bostick
Cc: Donald Lewis; Erin Crawford; Ed Bostick
Subject: RE: Eligibility Review

Debby

I wasn't actually looking for that language in those columns. The information that you already had for description of how the entity is eligible was fine. What we needed was the eligible entity type to be changed. Did you change the eligible entity types or just the description of how they were eligible?

Camelia

From: Debby Farreau [mailto:Debby.Farreau@cha.com]
Sent: Tuesday, June 04, 2013 2:48 PM
To: Camelia Rogers; Ed Bostick
Cc: Donald Lewis; Erin Crawford; Ed Bostick
Subject: RE: Eligibility Review

Camelia,

I have posted a modified version of the 465 Attachment to Sharepoint, per your request below in the fifth bullet. I modified the eligible entity types per your advice:

"A non-profit clinic that provides healthcare services and is located in an non-rural area should be listed as a Community Health Center for purposes of obtaining funding from the Rural Healthcare Support Mechanism. The FCC has not defined what a "community health center" means, so any non-profit health care provider that provides healthcare services to the community is eligible for funding. Non-profit clinics located in rural areas that are neither a Community Health Center or a Rural Health Clinic as defined by the Public Health Services Act can choose to which whichever eligible entity type best reflects the services that it provides to its patients."

I have also renamed the file "RFP03_Form_465_Attachment", since the RFP number was changed to 03 (see second bullet).

Please let me know if there is anything else I need to do or if you have any questions.

Thanks,
Debby

From: Camelia Rogers [mailto:crogers@usac.org]
Sent: Thursday, May 30, 2013 12:29 PM
To: Debby Farreau; Ed Bostick
Cc: Donald Lewis; Erin Crawford
Subject: Eligibility Review

Debby

A preliminary review of the documentation provided has been done and there are several issues that we will work with you to resolve. The action that we have taken thus far:

- Deleted FCC Form 465 from SharePoint: Since CTN is not initiating a competitive bid, a Form 465 is not necessary.
- Modified RFP number to 03 on the 465 Attachment in order to allow for a new set of 465 app numbers to be created for the new locations
- Modified names of documents on SharePoint: titles of all of the documents uploaded have been modified to remove (posted) from the names of the documents.
- Cursory review of the CMHC checklists. It appears that some of the locations are eligible and some are not eligible. We will send you a complete listing of the issues that we have identified
- Cursory review of the 465 attachment --- numerous HCP's are listed with incorrect Eligible Entity types. We would ask that Colorado Telehealth Network review the 465 Attachment and modify the eligible entity types to reflect the actual services provided at the physical locations. For example, there are multiple locations with "Not for profit Hospital" listed as the eligible entity type, but the description of services indicate that this is a Clinic. A clinic is not a hospital (even if owned by a hospital) and the eligible entity type needs to be modified to reflect the services provided at that physical location.

Please let me know once you have modified the 465 attachment. In the meantime, we are working on sending you a listing of the issues that we have found.

Thanks,
Camelia

Please take note, my office number has changed to 202-772-6289

Camelia L. Rogers, MPP
Manager of Consortia Applications
Rural Health Care Division
Universal Service Administrative Company
202-772-6289 (office)
202-341-7439 (blackberry)
crogers@usac.org

Attachment D:
Communication between Debby Farreau, Assistant Project Coordinator, and Erin Crawford, Assistant Program Analyst, confirming changes to 465 attachment based on title instructions and confirmation of 4 ineligible sites which did not include any Milestone Medical Group sites on 6/12/13.

From: Erin Crawford [mailto:ecrawford@usac.org]
Sent: Wednesday, June 12, 2013 11:50 AM
To: Debby Farreau
Cc: Camelia Rogers
Subject: RE: PreCommitment Eligibility Review for Colorado TeleHealth Network

Hi Debby!

Thank you so much for your response and the new information for the Touchstone site. I have read through your questions as well and, first of all, you are correct and I was mistaken in that there are four ineligible sites as Arapahoe Douglas Acute Treatment Unit is ineligible and thank you for sending these sites notification that they are ineligible. I also understand the connection for Jeffco and thank you for clearing up that issue as well. I have forwarded the LOA information as well as the updated 465 Attachment to Camelia for review and we will make the appropriate changes on our side as well to reflect this new information.

Thank you again for all of your help and we will have this all wrapped up for you very soon!

Erin

Erin Crawford
Assistant Program Analyst
Rural Health Care
Universal Service Administrative Company
2000 L St. NW, Suite 200
Washington, DC 20036
ecrawford@usac.org
202-572-1664

From: Debby Farreau [mailto:Debby.Farreau@cha.com]
Sent: Wednesday, June 12, 2013 12:14 PM
To: Erin Crawford
Subject: RE: PreCommitment Eligibility Review for Colorado TeleHealth Network
Importance: High

Erin,
Sorry that this has taken me so long. I have researched your questions and the answers are below in red. We also discussed the Touchstone site. I found out they provided me with and incorrect address. I corrected the address on the 465 Attachment and re-did their LOA (see attached) with the correct address. I also am attaching a screen shot from Touchstone's website that shows the

new site. I have also attached the updated 465 Attachment for your review before I repost it on Sharepoint.
Thanks,
Debby

From: Erin Crawford [mailto:ecrawford@usac.org]
Sent: Wednesday, June 05, 2013 9:07 AM
To: Debby Farreau
Cc: Camelia Rogers
Subject: PreCommitment Eligibility Review for Colorado TeleHealth Network

Debby,

My name is Erin Crawford and I am a newly hired Assistant Program Analyst working with the Rural Health Care Department here at USAC. I am on the pre-post commitment team and will work with you to determine the eligibility of the participating members for the Colorado Telehealth Network (fka Colorado Health Care Connections and Rocky Mountain HealthNet). I look forward to working with you and please do not hesitate to call or email with any questions or concerns you may while we work on determining eligibility of the participating entities. I have had the opportunity to familiarize myself with the Colorado Telehealth Network consortium and to review the HCP sites submitted for eligibility for the Healthcare Connect Fund. As a result of my review, I have a few questions regarding the eligibility and status of a few of the sites and would like to help define these entities in order to better suit their individual interests.

While reviewing the list of sites submitted for the Colorado Health Care Connection consortium, I found that a few 'Community Mental Health Centers' are residential facilities and are ineligible for enrollment in the program as well as sites that were classified as 'Non-Profit Hospital' or 'Rural Health Clinic' entities that are actually 'Health Care Clinics' classifiable as a 'Community Health Center'. We would like for you to please review this information and submit any verification for sites that may qualify as another entity type. There are currently three ineligible (aren't there four ineligible sites? Isn't Arapahoe Douglas Acute Treamtment Unit ineligible?) 'Community Mental Health Centers' according to USAC standards for 'Community Mental Health Centers'. In order to be eligible under the HCF program, a 'Community Mental Health Center' must be an outpatient facility offering only offering 24 hours emergency services and screening and rehabilitation services for patients. The ineligible sites are Jefferson Center for Mental Health in Aurora, Colorado West Regional Mental Health, Inc. – Women's Recovery Center and the Jefferson Center for Mental Health in Lakewood. Each of these HCP's is ineligible because they are residential facilities, but we would like to extend the offer of registering these sites as ineligible entities (I have sent the four ineligible sites an email letting them know that if they want to connect to CTN they will need to pay their "fair share".). We would also like to request a copy of a state license to operate for Jefferson Center for Mental Health (Jeffco Family Health Services) in Wheat Ridge. It seems as though this Center is serving a broad array of functions and we would like to verify their practices before we assign an entity type for the program. This is an integrated care site between Jefferson Center for Mental Health and Metro Community Provider Network (MCPN). The CTN connection will be funded by Jefferson Center for Mental Health. I left the entity type "Community Mental Health Center" since Jeffco is funding the connection.

Many entities listed by the Colorado Hospital Association are listed as 'Non-Profit Hospitals' but are in fact separate entities providing health care as a clinic and not as a hospital. A few other sites should be classified as 'Community Health Centers' instead of 'Not-Profit Hospitals' or 'Rural

Health Clinics'. A 'Rural Health Clinic' is a center providing outpatient and preventative health care in a rural area and operates as an individual entity that is a non for profit or for profit center. A 'Community Health Center' is devoted entirely to the health of a community and is a non-profit or public facility. Sites qualifying as a 'Community Health Center' are Heart of Rockies Regional Medical Center Medical Clinics, Monte Vista Clinic, South Fork Clinic and Middle Park Medical Center- Granby.(I changed these on the 465 Attachment.)

Attached is a listing of the HCP locations submitted by the Colorado Hospital Association consortium and the USAC classifications for eligibility and my notes for each site. The columns listing the designated number assignment for each HCP site may already have an assigned number, but many are listed as TBA or 'To Be Assigned' and will have HCP numbers once their eligibility is confirmed or they are entered into the USAC HCP database. There are also a few discrepancies in the data provided for these sites. For example, the correct HCP name for 'The Medical Clinics' is listed differently on the website of the HCP than is listed on the information provided by CTN (I changed this on the 465 Attachment to HRRMC Medical Clinics) and there are a few locations with a location HCP number already assigned but the information for the entity does not match the information being provided by CTN. If you could please provide us with additional information for these issues, it would be greatly appreciated. Please do not hesitate to contact me regarding any concerns or questions regarding HCP classifications for the Colorado Health Care Connections consortium entities and I look forward to working with you in the coming weeks.

Erin

Erin Crawford
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Rural Health Care
Universal Service Administrative Company
2000 L St. NW, Suite 200
Washington, DC 20036
ecrawford@usac.org
202-572-1664

Attachment E:
Communication between Debby Farreau, Assistant Project Coordinator, and Erin Crawford, Assistant Program Analyst, confirming eligibility of sites submitted on 465 attachment including Milestone Medical Group sites on 6/17/13.

From: Erin Crawford [mailto:ecrawford@usac.org]
Sent: Monday, June 17, 2013 12:09 PM
To: Debby Farreau
Cc: Camelia Rogers
Subject: Colorado Health Care Connections 465-Attachment

Hi Debby,

I have uploaded your 465-Attachment including the newly eligible sites to Sharepoint. You should be good to go as all of the new sites were reviewed and their eligibility status should be reflected in the 465-Attachment that is now uploaded to the Sharepoint site. Please do not hesitate to contact us with any further questions or comments regarding your project. A copy of the newly uploaded 465 Attachment is copied with this email.

Thank you!

Erin

Erin Crawford
Assistant Program Analyst
Rural Health Care
Universal Service Administrative Company
2000 L St. NW, Suite 200
Washington, DC 20036
ecrawford@usac.org
202-572-1664

Attachment F:
Communication between Ed Bostick, CTN Executive Director/HCF Project Coordinator and USAC Rural Health Care Division sent on 10/1/13 revoking eligibility of sites determined to be eligible on 7/29/13. Notification comes 29 days after USAC's failure to meet published FCL issuance deadline and three months after the good faith deployment of HCF sites previously deemed eligible by USAC.

Via Electronic Mail

10/01/2013

Ed Bostick
7335 East Orchard Road
Greenwood Village, CO 80111

RE: HCP 17212 Denial of Eligibility for 2 HCP's Longmont United Hospital District-Milestone Medical Group-Berthoud and Longmont United Hospital District-Milestone Medical Group-Niwot

Dear Ed Bostick:

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) received and initially reviewed the FCC Form 465 Package[1] submitted by HCP 17212, Colorado Health Care Connections on June 12, 2013. [2] USAC finalized processing the FCC Form 465 Package on July 29, 2013 with the posting of the competitive bidding package to the USAC search posted services website. [3] However, upon further review, several of the entities listed on the FCC Form 465 Attachment are not eligible to participate in the Healthcare Connect Fund.

In the Rural Health Care Pilot Program (RHCPP), entities that are "Non-rural Health Clinics" were eligible to participate and receive funding. The Pilot Program FCC Form 465 Attachment in Column 27(b) contained a dropdown menu with "Non-rural Health Clinic" as one of the Eligible Entity Types. Please note however that "Non-rural Health Clinic" is not an eligible entity type for purposes of the Healthcare Connect Fund. [4]

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[1] The FCC Form 465 Package includes the FCC Form 465 and all supporting documentation; including but not limited to, the Form, 465 Attachment, Network Plan, Scoping Document, Letters of Agency and Declaration of Assistance.

[2] As an existing Rural Health Care Pilot Program Pilot Project, Bacon County Health Services is allowed by the Healthcare Connect Fund Order to use existing Pilot Program forms to initiate competitive bidding for purposes of requesting funding through the Healthcare Connect Fund. *In the Matter of Rural Health Care Support Mechanism*, WC Docket 02-60, Report and Order, FCC 12-150, 22 FCC Rcd 16678 (2012) (*Healthcare Connect Fund Order*). "Existing Pilot Projects" refers to active Pilot Projects selected in the *2007 Pilot Program Selection Order*, including projects that have subsequently merged or otherwise restructured. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360 (2007) (*2007 Pilot Program Selection Order*).

[3] http://www.usac.org/rhc/healthcare-connect/tools/search-posted-services.aspx, last visited September 6, 2013.
[4] 47 C.F.R. § 54.600(a)

Entities that participated in the RHCPP as an "Non-rural Health Clinic" and received funding via the issuance of a Funding Commitment Letter as of the adoption date of the Healthcare Connect Fund Order[5] are eligible for funding as a "grandfathered entity" in the Healthcare Connect Fund. Alternatively, an "Non-rural Health Clinic" that meets the requirements of Section 330 of the Public Health Service Act[6] may be classified as a "Community Health Center" for purposes of participation in the Healthcare Connect Fund.

Upon further review of the "Non-rural Health Clinics" and the services they provide (as listed on the FCC Form 465 Attachment submitted by CHCC), USAC finds that they do not meet the definition of a "Community Health Center" as defined by the Public Health Services Act, Section 330. USAC also determined that those entities did not previously receive a funding commitment through the RHCPP as of December 12, 2012 and are therefore not eligible for "grandfathered entity" status under the Healthcare Connect Fund.

Although the above mentioned entities are not eligible to receive funding, they may register as an "Ineligible entity" if they plan to participate as part of a consortium, thus receiving the benefits of membership of a consortium.
If you wish to appeal this decision, you may file an appeal with USAC, or directly to the FCC. The appeal **must be filed within 60 days of the date of this letter.** Detailed instructions for filing appeals are available at: http://www.usac.org/rhc/about/program-integrity/appeals.aspx?pgm=telecom

If you have questions or need assistance, or if you believe you have received this email in error, contact Rural Health Care at 1-800-453-1546, between 8:00 a.m. and 4:30 p.m. Eastern Time Monday through Friday, or by email at rhc-assist@usac.org.

Sincerely,

/s/ Rural Health Care Division

[5] *Healthcare Connect Fund Order* was adopted by the FCC on December 12, 2012.
[6] http://bphc.hrsa.gov/policiesregulations/legislation/authorizing330.pdf, last visited August 6, 2013.